

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041445

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10040

FILED OCT 17 1963

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 11 Days | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 2211 Salisbury Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Joseph Finazzo | | 4. DATE OF DEATH Month Day Year October 8 1963 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3-14-1893 |
| 9. AGE (last birthday) 70 years | | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Floor Finisher | | 10b. KIND OF BUSINESS OR INDUSTRY Ace Floor Company | 11. BIRTHPLACE (City and state or country) Palermo, Sicily |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME Phillip Finazzo | |
| 13b. MOTHER'S MAIDEN NAME Marion Bono | | 14. NAME OF HUSBAND OR WIFE deceased | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. [redacted] | |
| 17. INFORMANT Marion Lesley 2211 Salisbury Street | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Lannulus Cirrhosis DUE TO (c) 581/1 | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from 9-27-63 to 10-8-63 and last saw her/him alive on 10-8-63 Death occurred at 7:15 PM m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Jelly B. McCants, M.D. | | 22b. ADDRESS St. Lukes Hospital | 22c. DATE SIGNED 10/9/63 (State) |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 10-11-1963 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 23d. LOCATION (City, town, or county) St. Louis Missouri |
| 24. FUNERAL DIRECTOR ADDRESS Math Hermann & Son, Inc. 2161 East Fair | | 25. DATE RECD. BY LOCAL REG. OCT 10 1963 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

USE BLACK INK
OR
TYPEWRITER RIBBON

INSTEAD OF

VS 300
Rev. 4/59

1

2

3

4

5

6

7

8

9

10

11

12

13

81

81

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Julius R. Brown

Licensed Embalmer No.

5146

P. O. Address

Shreveport, La.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.